CDHO
COLLEGE OF DENTAL HYGIENISTS OF ONTARIO

Form B – Therapist / Counsellor Information

THERAPIST / COUNSELLOR INFORMATION

SURNAME:	GIVEN NAMES:	DR. ○	MS. ○	MR. ○	OTHER:
BUSINESS ADDRESS:					
CITY:	PROVINCE:	POSTAL CODE:			
TELEPHONE NUMBER:	EMAIL ADDRESS:				
NAME OF CLIENT (APPLICANT FOR FUNDING):					

I am a current or former member of a regulated profession (e.g., psychologist, social worker, etc.) **YES** ○ **NO** ○

If "YES", please specify:

PROFESSION:

DATES OF REGISTRATION:

From: To:

Are your services to the Client covered, in whole or in part, by a government or private insurance program? **YES** ○ **NO** ○

BY SIGNING BELOW, I ACKNOWLEDGE AND CONFIRM THE FOLLOWING:

1. I will be providing therapy/counselling services to the Client, who has applied for or been granted funding under the program established by the College of Dental Hygienists of Ontario (the "College") for victims of sexual abuse by a Registered Dental Hygienist.
2. I do not have a family or personal relationship with the Client. I do not have any other relationship with the Client that would constitute a potential conflict of interest.
3. I have never been found guilty of professional misconduct of a sexual nature at any time or in any jurisdiction. I have never been found criminally or civilly liable for an act of a sexual nature.

4. I understand that any funding provided by the College will be determined by the Patient Relations Committee (the "PRC") in accordance with legislation. I understand that funding is subject to a maximum limit and a maximum duration as set out in legislation.
5. I understand that the amount of funding provided by the College may be adjusted to reflect other sources of funding and that there can be no duplicate payment for the same service.
6. I understand that any funds provided by the College can only be used for therapy/counselling services for the Client and for no other purposes. I understand that funds provided by the College cannot be applied to fees for cancelled or missed appointments.
7. I understand that any funds provided by the College will be paid directly to me; I agree to submit invoices to the College accompanied by Form D to receive payment.
8. I undertake to keep confidential all information obtained through the application for funding process, including whether funding has been granted and the reasons given by the PRC for granting or denying the funding, and to refrain from using that information for any collateral or ulterior purpose.

Therapist/Counsellor Signature

Date

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